VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086

Agency of Human Services

Denture Prior Authorization Request Form for individuals under age 21

(Effective 08/01/07)

(Please Print or Type)

1. Patient Information:

Name: _____

Date of Birth: _____Age: _____

Patient Address: _____

Patient Medicaid I.D. Number: _____

Restorative Treatment Completed to Date (check one - N/A only if edentulous): ☐ Yes ☐ No ☐ N/A

Oral Hygiene (check one - N/A only if edentulous): ☐ Good ☐ Fair ☐ Poor ☐ N/A

2. Denture Information: (Please answer **ALL** questions A-F)

A. Is patient edentulous on maxillary arch?
- ☐ yes. If yes, estimated number of years edentulous: _____
- ☐ no. If no, please indicate all remaining maxillary teeth by number: _____

B. Is patient edentulous on mandibular arch?
- ☐ yes. If yes, estimated number of years edentulous: _____
- ☐ no. If no, please indicate all remaining mandibular teeth by number: _____

C. Existing denture(s)? ☐ yes - go to question D
☐ no - go to question E

D. Please provide a brief description of the existing denture(s):

Upper denture: ☐ yes……type: _____
approximate age of denture: _____
condition of denture: _____
frequency of use: _____
☐ no

Lower denture: ☐ yes……type: _____
approximate age of denture: _____
condition of denture: _____
frequency of use: _____
☐ no

(Continue on back)

E. Do you expect the patient to tolerate and successfully adjust to the proposed treatment? ☐ yes ☐ no

F. Based on the patient's denture history, do you expect the patient to wear the proposed denture(s) on a regular basis? ☐ yes ☐ no ☐ n/a

3. Medical Information:

Medical Condition(s) making the requested denture(s) a medical necessity: _____

_____

_____

4. Additional Information:

_____

_____

_____

_____

5. Proposed Treatment:

Complete Denture:	☐ Maxillary (#D5110)	☐ Mandibular (#D5120)
Immediate Denture:	☐ Maxillary (#D5130)	☐ Mandibular (#D5140)
Resin-Based Partial:	☐ Maxillary (#D5211)	☐ Mandibular (#D5212)
Cast Partial Denture:	☐ Maxillary (#D5213)	☐ Mandibular (#D5214)
Overdenture:	☐ Maxillary (#D5860)	☐ Mandibular (#D5860)
Laboratory Reline:	☐ Maxillary (#D5750)	☐ Mandibular (#D5751)
Laboratory Rebase:	☐ Maxillary (#D5710)	☐ Mandibular (#D5711)
Pediatric Partial, fixed	☐ Maxillary (#D6985)	☐ Mandibular (#D6985)

6. Requesting Provider Information:

Provider Name: _____

Medicaid Individual and Group Provider Number(s): _____

Provider signature: _____

Date Submitted: _____

Submit this PA request and all supporting documentation to:

Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495
Fax: (802) 879-5963